From Policy to Implementation

Practical Implications of State Law Amendments Granting Nurse Practitioner Full Practice Authority

A CASE STUDY

National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention

Table of Contents

Introduction

Advanced Practice Registered Nurse (APRN) scope of practice (SOP) and licensure laws determine "the types of services APRNs may perform independently or under the direct supervision of or through a collaborative agreement with a physician or other provider."[1] In 2010, the Institute of Medicine (IOM)[a] released a report, *The Future of Nursing: Leading Change, Advancing Health*, commissioned by the Robert Wood Johnson Foundation that found that state statutes and regulations often restrict the ability of APRNs to provide care to the full extent of their education and training.[2] The IOM and the National Council of State Boards of Nursing endorsed a full practice authority (FPA) service delivery model that allows a nurse practitioner (NP), one type of APRN, to perform the following range of services independently: patient evaluation and diagnosis; ordering and interpretation of diagnostic tests; and initiation, prescription, and management of medications and treatments. As of April 2016, 21 states and the District of Columbia had laws in effect granting NP FPA, and an additional 8 states granted NP FPA after a transition-to-practice period working under the supervision of a physician or NP.[3]

To some extent, APRNs, such as NPs, and other non-physician health providers are trained to provide certain health care services independently. With regard to primary health care and preventive services, the patients of NPs have health outcomes comparable to those of patients of physicians.[4] Studies also found similar levels of patient satisfaction, blood pressure and blood glucose control, health status, and emergency department visits and hospitalizations for patients treated by NPs compared with physicans.[4] Furthermore, NPs may help address primary care provider shortages for medically and geographically underserved populations.[5,6]

Allowing health professionals to practice at the top of their licensure and training is also a strategy to facilitate interprofessional team-based health care and coordinated models of high-quality, cost-effective service delivery.[7] In the 2010 *The Future of Nursing* report, the IOM defines team-based health care as "the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care."[2] A variety of primary care providers, including NPs and clinical nurse specialists, can lead health care teams. The IOM 2010 report recommended expanding opportunities for nurse-led collaborations with physicians and other health providers, as well as a greater role for NPs in health delivery system design and diffusion.[2]

This report describes some of the benefits and challenges that NPs experienced in providing health care services after state law amendments granted FPA with a transition-to-practice requirement.

> Full practice authority has been defined as "the collection of state practice and licensure laws that allow for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, [and] initiate and manage treatments—including prescribing medications—under the exclusive licensure authority of the state board of nursing."[1] In 2016, 21 states and the District of Columbia had laws granting full practice authority.[3]

a The IOM has been renamed the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine.

Methods

NP stakeholders in two states were interviewed about their perceptions and experiences in delivering health care before and after NPs attained full practice authority. Less densely populated states with rural and frontier health access challenges that amended their nurse practice acts between 2010 and 2015 were considered. Researchers wanted to ensure that enough time had passed for FPA to be implemented, yet little enough time had passed that practitioners would be able to speak to both the "before" and "after" aspects of the policy change. Two states meeting these criteria were selected: Nevada granted NP FPA in 2013,[8] and Minnesota granted NP FPA in 2014.[9] Both states have a transition-to-practice requirement.

A convenience sample of prospective interviewees from each state was identified through e-mail and phone contacts with each state's nursing board and advanced practice nurses association, as well as the American Association of Nurse Practitioners. Nine NPs from clinical practices, academia, health care organizations, and professional organizations agreed to participate in telephone interviews over a 6-week period in 2016 that followed a structured informant interview guide. The questions were open-ended to gather information about the NP's area of practice, unique information about the patient population and health care facility, how the amended laws were implemented in their state, and other policy changes over time that affected NP practice. The interviews were analyzed for themes as well as unique response characteristics.

This report summarizes the findings and discusses possible implications for interprofessional team-based care approaches to chronic disease management. The intent is to help guide practitioners, payers, decision makers, and others considering policy changes to expand the primary care workforce capacity and increase access to primary and preventive health services for chronic disease management.

Context

Overview of NP Practice Authority Laws in Nevada

The Nevada legislature granted FPA to NPs during the 2013 legislative session with passage of 2013 Nevada Laws Ch. 383. This law, effective July 1, 2013, removed the requirement that an NP practicing in Nevada have a collaborating physician–approved protocol to diagnose and treat patients. However, NPs must complete either 2 years or 2,000 hours of clinical practice to prescribe medications independently. In addition, APRN was added to the definition of "practitioner" in the state's pharmacy practice act, allowing NPs to enter into collaborative practice agreements with pharmacists to provide drug therapy management and other NP-delegated services. Interviewees discussed the impact of the law granting FPA on practicing NPs in the 3 years since the law took effect.

Overview of NP Practice Authority Laws in Minnesota

NPs in Minnesota achieved FPA with passage of 2014 Minn. Sess. Law Serv. Ch. 235 that amended the Minnesota Nurse Practice Act and revised the SOP of APRNs.[10] The new law, effective January 1, 2015, removed the requirement for NPs to have a collaborating physician and authorized NPs to function as primary care providers, perform advanced assessments, diagnose patients, prescribe, and order treatments. The law added a transition-to-practice requirement that NPs have at least 2,080 hours of professional practice under a collaborative agreement in a hospital or an integrated clinical setting. Interviewees discussed the impact of the law granting FPA to practicing NPs in the year and a half since the law took effect.

Table 1. Relevant Statutes and Regulations for This Case Study

	Relevant Statutes and Regulations
Nevada	• NEV. REV. STAT. ANN. §§ 632.012 and 632.237 (West 2016); • NEV. ADMIN. CODE § 632.061 (2016)
Minnesota	• MINN. STAT. ANN. §§ 148.171, 148.211, and 148.235 (West 2016); • MINN. R. 6305.0100 to 6305.0800 (2016)

Implementation of NP FPA

One NP involved in the passage of FPA legislation said, "Many NPs wishing to have their own practice were paying fees to [physicians] ranging from a token 'few hundred dollars' to tens of thousands of dollars per year."

To better understand the impact of FPA, interviewees in both states first described some of the common challenges that NPs experienced before legislation granting FPA with a transition-to-practice requirement took effect. When FPA was implemented in their state, NPs experienced a less restrictive practice environment. Three main themes emerged from the interviews: the challenges that NPs experienced before FPA took effect, the barriers and facilitators to FPA implementation, and the lessons learned by the NPs since FPA was granted.

NP Practice Restrictions Before FPA Implementation

NPs found that the process of establishing a collaborative agreement was time-intensive and expensive. Before the legislative changes in Nevada and Minnesota, NPs were required to have a collaborative agreement with a physician to oversee their practice. NPs reported several concerns with mandatory collaborative agreements. Executing or modifying collaborative agreements created administrative burdens for both the NPs and the physicians. The process of drafting or amending a collaborative agreement and filing it with the state board of nursing or medicine was time-consuming and costly. Some interviewees explained that NPs typically were required to pay the collaborating physician a monthly fee for the physician's oversight services, even if the providers consulted infrequently or on an as-needed basis. Under FPA, the time, effort, and cost of executing a collaborative agreement were eliminated for NPs beyond the transition-to-practice requirement.

NPs experienced difficulty finding a physician to collaborate with because of a limited pool of physicians and restrictions on how many NPs they could oversee. Interviewees in both states noted the difficulty of finding one or more physicians willing to collaborate so that the NP could actively provide health services, noting that physicians had liability concerns. In addition, limits on the number of NPs with whom a physician could collaborate (e.g., a physician in Nevada could oversee a total of three nurse practitioners and/or physician assistants) reduced the pool of available collaborating providers and created additional hardships for NPs with rural practices. NPs risked losing or temporarily ceasing their practice if they executed a collaborative agreement with just one physician. If the collaborating physician died, retired, changed practices, or terminated the collaborative agreement, the NP was required to put their practice on hold until they executed a new agreement with another collaborating physician.

After the laws were amended, the pool of physicians available for collaborative agreements became less of an issue, because it is necessary for NPs only during the transition to practice.

An interviewee working in rural Nevada described a situation in which the physician overseeing an NP clinic providing obstetrics care to women passed away suddenly. Since it was the only clinic providing obstetrics care within hundreds of miles, the NP clinic was forced to shut down until another collaborating physician could be found.

Implementation Barriers

Ongoing legal and institutional challenges were considered a barrier to NPs practicing to the full extent of their training, education, and skills. In Minnesota, NPs are still prohibited from signing a death certificate for a patient under their care, but they may sign disability placard forms. A pediatric NP caring for infant patients after birth explained that Minnesota NPs are prohibited from discharging a patient from the hospital, creating a barrier to providing care for those patients. NPs in both states explained that some hospitals still require collaborative agreements between NPs and physicians, although the law no longer requires these agreements. Some large health care organizations cite company policy as the reason to continue to use collaborative agreements.

Business costs may be a barrier to scaling up NP-led practices. Many NPs remain afraid to take the next steps to own their practice and become independent business owners. Minnesota interviewees explained that the cost of operating an NP practice is another barrier. While interviewees found it significantly less expensive to operate without the added cost of physician collaboration, it is still expensive to open up a practice, and there is risk involved. Many NPs are comfortable in their current employment arrangements and understand that setting up an independent practice can be a daunting task.

Perceptions of the ability of NPs to provide comparable services may limit growth of NP services. Interviewees found that patients in Minnesota reacted positively to the increase in access to NP primary care and other services. Nevertheless, interviewees expressed a sentiment that people believe that NPs should be paid less than physicians for the same services because of perceptions that NPs do not have the same level of education as physicians. This continued to be a source of contention for NPs practicing in Minnesota.

Implementation Facilitators

Growth in the number of practicing NPs may increase access to care in rural and underserved areas. Two years after FPA became effective in Nevada, several interviewees, including those working in the field of nursing education, indicated rapid growth in the number of practicing NPs, including more NP graduates staying within the state to practice and more moving into the state to practice. Interviewees explained that few physicians are willing to practice in rural areas for extended periods and that the number of available practicing physicians is extremely limited. It was also noted that rural populations are some of the most vulnerable to chronic diseases and often have lower quality of health overall. Interviewees thought that FPA would help address these gaps in care by increasing the number of primary care providers, creating opportunities to provide tailored care, and creating nontraditional care settings for chronic disease management (e.g., home care for vulnerable populations). Interviewees said that access to primary care had improved in underserved areas, because NPs were taking their practices into less traditional remote and rural areas. Nevada interviewees described examples of NP-led clinics in rural areas that quickly started to see a wide range of patients. Interviewees also stated that NPs were leveraging FPA and working to turn their practices into successful NP-led health care organizations.

Innovative primary care services may address access barriers in NP-led clinics. Interviewees in Minnesota described NP-led clinics in urban areas treating underserved populations, such as elderly and chronically ill populations (including Medicaid and Medicare beneficiaries). One interviewee described the challenges that underserved

populations in urban areas experience in accessing health care: Patients may be unable to travel to a doctor's office for an appointment, be unable to see a physician during normal business hours, or lack the health education to seek medical help. NP practices are serving patients outside of traditional hours, thus accommodating patients who may not have sought care in the past. For example, NPs are using mobile clinics to reach patients in a broad range of settings and at different times, which allows them to reach the populations with the highest prevalence of chronic disease and reduce the likelihood of emergency department readmissions. Minnesota interviewees described other ways in which NP clinics were providing health care to reach a wider population, such as working in communities to bring more face-to-face care to patients through home care and combining primary care with mental health care.

Lessons Learned

Since the passage of FPA, interviewees indicated that NPs have been asked to participate in legislative committee sessions from which they were previously excluded. NPs in both states reported being included in more recent policy initiatives. Interviewees believe that this indicates that perceptions about NPs have improved and that legislators are becoming more knowledgeable of NPs within the medical field.

FPA gives NPs the ability to practice in innovative and nontraditional care settings such as home care, community settings, and expanded hours. NPs can focus on chronic disease management in these nontraditional settings. However, as more NPs enter the workforce and take advantage of the opportunities that FPA provides, organizations may consider aligning internal policies with state policy. The most innovative group appears to be recent NP graduates who are open to novel practice ideas. Interviewees were hopeful these new NPs would develop inventive care models to address the changing health care needs in the state.

Time and education are needed. All interviewees indicated that over time, graduating NPs become more comfortable practicing independently, and graduating physicians become more accepting of working with them. Providers, patients, and health care organizations need time to adjust to FPA and become comfortable with a new way of practicing medicine. These changes may give willing medical professionals the opportunity to provide patient care in many unique ways, leading to improved population health outcomes and potentially greater health equity. It will take time to educate stakeholders and evaluate how FPA is put into action to determine whether the policy change is working.

Summary and Conclusions

In the 2010 *The Future of Nursing* report, the IOM found that state statutes and regulations often restrict NPs' ability to provide care to the full extent of their education and training. To address this, the IOM report made several recommendations in support of NP FPA and the removal of NP SOP barriers.[2] This case report describes benefits and ongoing challenges that NPs experienced after they gained the legal right to practice autonomously in Nevada and Minnesota, two states that granted FPA with a transition-to-practice period. The case report findings, while informative, have some limitations. First, potential recall, confirmation, and selection bias could have been introduced into the report on the basis of the convenience sample that was used. Quantitative data on patient outcomes and health care costs in states with NP FPA, before and after FPA legislation was adopted, could be included in future assessments to build upon the findings of this report. Second, only nine NPs across two states were interviewed. Broadening the scope to include stakeholders representing health care organizations, other health care providers, payers, patients, and other relevant stakeholders in future assessments may provide a more complete picture of the NP FPA effect. Lastly, both selected states, Nevada and Minnesota, require NPs to complete a transition-to-practice period before attaining FPA.[3] States that did not require NP FPA transition to practice beforehand were not included. Future assessments of the impact of FPA in states with and without transition-to-practice requirements may reveal additional barriers to or facilitators of NP FPA implementation.

According to interviewed NPs, the perceived benefits included the ability to spend more time and resources focusing on health care delivery instead of the administrative burdens partly associated with obtaining and managing collaborative agreements with physicians. Interviewees cited an increase in the number of practicing NPs since FPA was granted, including new graduates and NPs from other states. Another perceived benefit is that, along with the health care workforce increase, NPs have been able to reach broader populations and underserved groups, such as the elderly and people with multiple chronic conditions in both rural and urban areas. Nevada and Minnesota NPs are developing and implementing innovative approaches to health care delivery, including using mobile clinics, home-based care, and seeing patients outside of normal business hours. These findings corroborate the results of recent studies that have found that states with laws that limit NP practice authority to a greater degree have fewer practicing NPs and slower growth in new employment of NPs,[10,11] whereas states that authorize NPs to practice independently have larger annual percentage increases in patients seen by NPs.[12]

Institutional challenges still exist, as larger health organizations continue to require collaborative agreements between providers. Several interviewees believed that NPs needed to educate stakeholders about the value of their services in order to address perceptions about parity in payment for similar services provided by physicians. However, there are opportunities for graduating NPs to create more innovative models of care and operate their own practices. Additionally, health care organizations may consider adopting policies and practices that take advantage of the authority provided to NPs in law to alleviate primary care provider shortages and reach more underserved populations. In both states, NPs became a resource for their state legislators in considering new policies. Over time, these changes have the potential to educate providers, patients, and health care organizations about NP capacity and value in providing health care services that NPs are trained and educated to perform.

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Disclaimer

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